Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ADVANTASRX
2805 PEACHTREE INDUSTRIAL BLVD SUITE 112
DULUTH GA 30097

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box

Box Number 1

MFDR Tracking Number

M4-12-0853-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At AdvantasRx, we determine the amount to bill using Texas Administrative Code 134.503 section (a) paragraph (2). AdvantasRx uses Medi-Span exclusively to determine AWP… The AWP used to calculate the Bill Amount is valid for the Date of Service in question. The pharmacies to which AdvantasRx provides services do not have negotiated or contracted amounts with insurance carriers. AdvantasRx does not have contracts with any insurance carrier. With the reasoning and evidence provided AdvantasRx believes **Liberty Mutual** should pay the full amount of the original claim plus any interest owed."

Amount in Dispute: $11.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per Rule 133.307 a request for medical dispute resolution must be submitted within 1 year of the date of service. TDI/DWC revceived this request on November 14, 2011 in regard to date of service November 8, 2010. The request is not timely. The charges were reimbursed according to the medical fee guidelines using the AWP per Blue Book. No additional reimbursement is due."

Response Submitted by: Liberty Mutual Insurance Co., PO Box 3423, Gainesville, GA 30503

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
November 8, 2010	AMITIZA	$11.42	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes: for dates of service:
   - Z650 – Charge for this procedure exceeds average wholesale price plus mark-up.
   - X598 – Claim has been re0evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Were all the services in dispute filed in the form and manner prescribed by the division?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c) states, in pertinent part, that "[a]requestor shall timely file with the Division's MDR Section or waive the right to MDR." Rule 133.307(c)(1)(A) explains that "[a]request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." This medical fee dispute was received on November 14, 2011. The date of service is November 8, 2010. The request for medical fee dispute resolution for the date of service November 8, 2010 was not filed within one year and does not involve issues identified in Rule 133.307(c)(1)(B); therefore the request for this date of service does not meet the requirements of 28 Texas Administrative Code §133.307(c)(1)(A).

2. The division concludes that the requestor has waived the right to medical fee dispute resolution for the November 8, 2010 services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 20, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), **including a certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.